STATEMENT OF
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NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ON
H.R. 4939, VETERANS MEDICARE PAYMENT ACT OF 2002

JULY 16, 2002

Mr. Chairman and Members of the Committee:

Once again, The American Legion applauds the bold leadership of this Committee. Thank you for including The American Legion in this hearing.

The American Legion continues to actively advocate authorizing the Department of Veterans Affairs (VA) to be a Medicare provider for the treatment of Medicare-eligible veterans' nonservice-connected medical conditions. The American Legion fully supported the enactment of Public Law (P.L.) 104-262 that authorized eligibility reform and opened enrollment in VA's health care system within existing appropriations. Clearly, millions of veterans -- previously locked out of the system -- have enthusiastically enrolled to meet their unique health care needs for many legitimate reasons:

- VA's quality of care,
- VA's holistic approach to health care,
- VA's full continuum of care to include specialized services,
- VA's medical and prosthetics research,
- VA's affiliation with over 100 medical schools,
- VA's renown patient safety record,
- VA's numerous health care facilities,
- Affordability of care, and
- Camaraderie.

In order for more veterans to access VA health care, additional revenue streams must be generated to supplement (not offset) annual discretionary appropriations. Annual discretionary appropriations for medical care are primarily designed to provide funding for the care of veterans assigned to Priority Groups 1-6, medical and support personnel, research, medical affiliations, its infrastructure and capital assets. The annual discretionary appropriations are distributed throughout the system via the Veterans Equitable Resource Allocation (VERA) formula which takes into account numerous factors; however, the number of enrolled Priority Group 7 veterans or Medicare-eligible veterans are not funding components.

Wisely, Congress authorized VA to bill, collect, retain, and reinvest all co-payments, deductibles, and third-party reimbursements. This provides VA with much needed additional

resources; however, these funds are scored as an offset against the annual discretionary appropriations. When VA does not meet its projected collection goals, the health care system experiences a budgetary shortfall. Such shortfalls result in limited health care services and timeliness of access. Third-party reimbursements primarily come from private health insurance providers. Unfortunately, under current law, VA is prohibited by Federal statute from billing the country's largest Federally-mandated, pre-paid health insurance provider – Medicare.

A large number of veterans seeking health care services in VA are Medicare-eligible and list Medicare as their health insurance provider. Others list health maintenance organizations (HMO) that traditionally refuse to reimburse VA for treatment of their health care beneficiaries. Others list preferred providers organization (PPO); however, VA is not listed as a preferred provider – therefore, will not be reimbursed for care. Finally, many veterans list no private health care coverage at all.

The American Legion strongly advocates Congress reconsider authorizing VA to bill, collect, and retain third-party reimbursements from the Centers for Medicare and Medicaid Services (CMS) for treatment of Medicare-allowable, nonservice-connected medical conditions of Medicare-eligible veterans. Since Medicare is a Federally-mandated, pre-paid health insurance program, The American Legion believes Medicare-eligible veterans should be allowed to choose their health care provider. If VA is a Medicare-eligible veteran's health care provider of choice, then VA should be reimbursed for providing quality health care services.

Since VA is a Federal health care system, Congress should expect fewer incidents of the fraud, waste, and abuse which frequently occurs throughout the private health care industry. Additionally, VA billing should be well within the limits of Medicare allowable rates for authorized services. Finally, unlike the private health care industry, VA – as a Medicare provider -- would be completely under the governmental oversight of Congress.

Turning to H.R. 4939, Veterans Medicare Payment Act of 2002, The American Legion is deeply concerned with this approach to the Medicare reimbursement issue. This legislation would seek to provide a transfer of the veteran's Part B premium as a payment to VA for outpatient care furnished to Medicare-eligible veterans from CMS. Although this would represent a small step in the right direction, it would continue to discriminate against Medicare-eligible veterans by prohibiting them from receiving the full benefit of their financial investment. It would also prohibit VA from having the much-needed resources to meet the growing demand for providing quality health care to America's veterans, especially those commonly referred to as the Greatest Generation.

Allowing VA to receive the Part B Premium is not how Medicare reimbursement works in the private sector or any other Federal health care system. The DoD Medicare demonstration project was a clear example of how dramatic deviation from the normal process is destined for failure. Under this "special arrangement" DoD experienced two unique Medicare rules – maintenance of effort and reduced reimbursement. No other Medicare provider, public or private, faced these unique Medicare reimbursement provisions.

Maintenance of effort or level of effort required DoD to treat a pre-determined number of Medicare-eligible patients before it could bill Medicare for treating a Medicare-eligible DoD beneficiary. The fact that DoD beneficiaries were also Medicare-eligible had absolutely no relevance to their access to care. The logic of this requirement is beyond plausible rationale since eligibility for treatment within DoD is based on honorable military service and has absolutely nothing to do with Medicare-eligibility.

The reduced reimbursement was clearly another aberration unique to DoD. No other public or private Medicare provider faced reduced reimbursements. Clearly, this was a premeditated initiative to financially discourage the project; however, Congress enacted TRICARE for Life. TRICARE for Life is an extremely effective version of Medicare reimbursement for Medicare-eligible retired military personnel and their dependents.

Medicare provides health care financial assistance for nearly 40 million Americans. Generally, an individual is eligible for Medicare if they or their spouse worked for at least 10 years in Medicare-covered employment, is 65 years of age or older, and a citizen or permanent resident of the United States. Others may qualify for coverage if they are under age 65 with severe disabilities or with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant). However, nearly every working person in the United States is mandated to make monthly contributions to Medicare throughout their career. Veterans are no exception. As members of the U.S. workforce, they have paid into the Medicare system, yet they are denied this entitlement if they chose to seek treatment at VA because VA is prohibited from billing and collecting Medicare reimbursements for the treatment of nonservice-connected medical conditions of enrolled Medicare eligible veterans.

Mr. Chairman, your legislation would amend part B (Supplementary Medical Insurance) of title XVIII (Medicare) of the Social Security Act to provide for a transfer of payment to the VA for outpatient care furnished to Medicare-eligible veterans by the Department. Granted, this bill would ensure that the Part B Medicare premium, paid by veterans to the Federal government, would be reinvested in VA. However, The American Legion would rather see legislation similar to that which authorized Indian Health Services (IHS) to become a Medicare and Medicaid provider. IHS was not faced with either maintenance of effort or reduced reimbursements provisions. Why should VA be denied full reimbursement for the treatment of nonservice-connected medical conditions of Medicare-eligible veterans?

Authorizing CMS to transfer the monthly Part B payment in lieu of the entire allowable reimbursement would be an option private health insurance providers would rather pay to VA as well. IHS does not receive a transfer of the monthly Part B payment. No private health care provider receives a transfer of the monthly Part B payment. Why should VA have to settle for this unique provision?

Clearly, IHS serves as an excellent example of how the quality, accessibility, and timeliness of health care can dramatically improve with new revenue streams that supplement rather than offset annual discretionary funding. Working closely with CMS, IHS successfully developed an effective and efficient third-party billing and collection system. Using IHS as a model, VA and CMS can emulate this achievement.

Opponents of allowing VA to receive Medicare reimbursements have argued that it would constitute "double-dipping" by veterans because Congress provides VA with annual discretionary funding for medical care. This is absolutely illogical. Access to VA health care is based purely on honorable military service – an earned benefit. Access to Medicare is Federally mandated and pre-paid by each beneficiary from automatic payroll deductions from personal wages. If VA were to bill CMS for treatment of service-connected health care, "double-dipping" allegations would be understandable; however, The American Legion believes Medicare reimbursements are justifiable for only nonservice-connected medical conditions. Furthermore, if the Federal government believes private health insurance companies should pay for the cost of treatment of nonservice-connected conditions, then the Federal government should be willing to set the example.

The American Legion is impressed by the entire IHS third-party reimbursement cycle. Comparing IHS' and VA's third-party reimbursement cycles, The American Legion noticed three major differences: leadership's focus on the coordinated effort throughout the entire cycle, more emphasis on accounts receivable than billing, and the training and use of certified coders.

- The leadership within IHS recognized that the effectiveness of third-party reimbursement collections had a direct impact on the quality of care provided by the system. With flat-lined annual discretionary funding levels, third-party reimbursements were the only means of generating additional, much needed health care dollars. IHS has successfully convinced everyone in the reimbursement cycle how critical each element is in the cycle. Every component plays an interdependent role, from administrative staff to health care providers to certified coders to collections, it is a team effort.
- Initially, IHS' primary focus was on billing rather than collections. Although the billing was working extremely well, accounts receivable were receiving less attention. Much needed revenue was slipping through their fingers because billing questions were not being effectively answered in a timely manner resulting in claims exceeding billing deadlines.
- Certified coders also proved to be a critical factor. Yet, the Office of Personnel Management (OPM) does not authorize VA or IHS to have full time employees (FTE) as certified coders. The American Legion finds this disturbing and an unsound business practice. Certified coders in the private sector are paid wages compatible to their skill level, yet OPM fails to recognize their value within the Federal government performing the same function as in the private sector.

Congress -- not CMS -- prohibited VA from receiving third-party reimbursements from Medicare; therefore, it is Congress – not CMS – that can modify this mandate and allow VA to bill CMS for allowable nonservice-connected medical conditions. If a Medicare-eligible veteran goes to a private health care provider and is treated for a service-connected or nonservice-connected medical condition and Medicare covers the entire cost of care; then that veteran should enjoy the same benefit within VA. If one Federal health care provider can receive Medicare reimbursements with superficial provisions, then all Federal health care providers should be treated equally. Since the enactment of TRICARE for Life, the Medicare reimbursement disconnect between VA and TRICARE jeopardizes close coordination of health care delivery for Medicare-eligible TRICARE beneficiaries in VA facilities.

Mr. Chairman, H.R. 4939 offers an untested approach to allowing VA to serve as a Medicare provider and seek reimbursements from CMS. There is a good chance that the actual cost of care and collecting of the Part B premium could exceed the total amount of the premium – resulting in a zero sum (or more likely an overall deficit) episode – similar to the failed DoD demonstration program. IHS conducted a five-year demonstration project that became permanent because of its overwhelming success in achieving it primary goal – improve the quality of care for its beneficiaries. The American Legion shares that goal and vision for VA.

The American Legion strongly encourages this Committee to consider legislation that emulates the IHS or TRICARE for Life approach in lieu of H.R. 4939.

Mr. Chairman, that concludes my testimony. I welcome your questions. Thank you.